Regional Infection Prevention and Control
Clinical Practices Audit Tool
For
Augmented Care Areas

Organisation Name:

Area Inspected/ Speciality:

Auditors:

Date:

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Regional Infection Prevention and Control Clinical Practices Audit Tool for Augmented Care Areas – Guidance

This audit tool is designed to be used in conjunction with the Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool.

This tool is to help provide assurance that there are robust systems and processes in place to provide a consistent approach to clinical interventions, reducing the risk of infection to patients, visitors and staff and that standard infection prevention and control precautions are applied by all healthcare practitioners in the delivery of care to all patients.

Questions within the various subdivisions in the section are based on best practice guidance and high impact interventions (HII) or care bundles, which are evidence based care processes, related to key clinical procedures that have been shown to reduce the risk of infection if performed appropriately. **This section contains nine interventions and has been devised for use in various clinical settings.**

The audit tool is formatted as follows:

Section 2 Regional Infection Prevention and Control Clinical Practices Audit Tool for Augmented Care Areas

Section 2.1 Aseptic non touch technique (ANTT)
Section 2.2 Invasive devices – There are systems and process in place to ensure a standardised and consistent approach in the insertion and on-going maintenance of invasive devices
Section 2.3 Taking Blood Cultures
Section 2.4 Antimicrobial prescribing
Section 2.5 Clostridium difficile infection (CDI)
Section 2.6 Surgical site infection
Section 2.7 Ventilated (or tracheostomy) care
Section 2.8 Enteral Feeding or tube feeding is defined as a mode of feeding that delivers nutrients directly into the stomach, duodenum or jejunum (Gastrostomy, Jejunostomy, Naso/orogastric tubes)
Section 2.9 Screening for MRSA colonisation and decolonisation
Documentation for the Regional Infection Prevention and Control Clinical Practices Audit Tool for Augmented Care Areas

Scoring

All criteria should be marked either yes/no or non-applicable.

It is not acceptable to enter a non-applicable response where an improvement may be achieved. For example where a regional/national standard is not being met, a non-applicable must not be used:

Section						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Antimicrobial prescribing and management guidelines are available	1. Up to date guidelines have been developed (view guidelines)					

***R = Designated area of responsibility i.e. Nursing, Estates and Cleaning**

In the example above it is not appropriate to mark non-applicable where antimicrobial prescribing and management guidelines are not available as the regional standard is to have them. Therefore if they are not available a no score must be allocated. The action plan will then reflect the change in practice required.

If a question is not achievable because a facility is absent or a practice is not observed, the use of non-applicable is acceptable. For example if infusions drainage systems are not in use.

Section 2.2 Invasive Devices						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Infusions (IV) or drainage systems are maintained as closed systems	1. Infusions are maintained as closed systems (Observe)			***X***		
	2. Drainage Systems are maintained as closed systems (Observe)			***X***		

Comments should be written on the form for each of the criteria at the time of the audit clearly identifying any issues of concern and areas of good practice. These comments can then be incorporated into the final report.

Manual scoring can be carried out as follows:

Add the total number of yes answers and divide by the total number of questions answered (including all yes and no answers) excluding the non-applicable; multiply by 100 to get the percentage.

Formula

$$\frac{\text{Total number of yes answers}}{\text{Total number of yes and no responses}} \times 100 = \%$$

Section						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Catheter/cannula insertion site is regularly inspected and the appropriate dressings is in use	1. Dressings are sterile, adherent, transparent and semi permeable (observe)		✓			
	2. Regular observation of site – at least daily for signs of infection(hourly IV/CVC check for neonates, renal catheter site at the beginning of each dialysis session) (check records)	✓				
	3. Dressings are intact and dry at the time of inspection and changed regularly if transparent dressing not in use (observe/check documentation)	✓				
	4. Urinary catheters – daily meatal hygiene is carried out (check records)		✓			

The score for the above table would be calculated as follows:

2/4 x 100 = 50%

Level of Compliance

Percentage scores can be allocated a level of compliance using the compliance categories below.

Compliance levels should increase yearly to promote continuous improvement.

Year 1

Compliant	**85% or above**
Partial compliance	**76 to 84%**
Minimal compliance	**75% or below**

Year 2

Compliant	**90% or above**
Partial compliance	**81 to 89%**
Minimal compliance	**80% or below**

Year 3

Compliant	**95% or above**
Partial compliance	**86 to 94%**
Minimal compliance	**85% or below**

Organisations when monitoring high impact Interventions should base compliance levels at 100%

Each section within the audit tool will receive an overall score. This will identify any specific areas of partial or minimal compliance and will assist in the identification of areas were improvement is most required to ensure that the appropriate action is taken.

Weighting Criteria

Millward et al (1993) reported that weighting of the criteria did not significantly influence overall scores. Therefore weighting of criteria has not been attempted.

Auditing

The audits obtain information from observations in functional areas including, direct questioning of staff, patients, carers, observation of clinical practice and review of relevant documentation where appropriate.

If any serious concerns are identified during the audit, these should be brought to the attention of the person in charge before the auditors leave the premises and where necessary escalated to senior management.

Feedback

Verbal feedback of key findings should be given to the person in charge of the area prior to leaving or as soon as possible. A written copy of the findings and actions required should be made available to all relevant personnel within locally agreed timescales.

A re-audit of a functional area may be undertaken if there are concerns or a minimal compliance rating is observed to ensure action has been taken.

Section 2.1 – Aseptic non touch technique (ANTT)

Question	Guidance	Yes	No	N/A	R	Comments
1. An ANTT policy is available	1. An ANTT policy or equivalent is in place					
	2. Staff are aware of and can access ANTT policy					
	3 The policy is reviewed on a regular basis					
2. Staff have received training on ANTT	1. Staff have received training e.g. online training/face to face/DVD					
	2. Training updates are provided in accordance with changes in regional/evidence based guidelines					
3. Staff can demonstrate when ANTT procedures are applied e.g. (observe/ask staff)	For example: 1. Wound care					
	2. Preparation and administration of IV Drugs					
	3. Administration of blood products					
	4. Urinary catherisation					
	5. On insertion of CVC (Surgical ANTT)					
	6. Device insertion e.g. cannula, drains, PICC lines (Surgical ANTT undertaken were appropriate)					
4. Hand hygiene is an integral part of the ANTT procedure	1. Hand hygiene is carried out in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
	2. Hand hygiene is audited in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
5. Hand washing is carried out in line with HSS (MD) (16/2012)	1. Staff use alcohol gel after hand washing when caring for the patient					
6. ANTT assessments (as part of clinical procedures) are undertaken	1. The ward manager or nominated person undertakes an audit of staff practice (review audit results)					
	2. Compliance is independently verified if infection rates and audit scores identify poor practice, if self-scoring or validation compliant scores are low (review documentation)					

	3. Action plans are devised if required to improve practice					
7. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	Yes	No	N/A
Percentage achieved			

Section 2.2 – Invasive devices – There are systems and process in place to ensure a standardised and consistent approach in the insertion and ongoing maintenance of invasive devices						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Policies/procedures/care bundles are in place for the insertion and on-going management of invasive devices	1. Policies/procedures/care bundles are in place e.g. Central venous catheters (CVC), Peripheral intravenous catheters (PVC) and urinary catheters					
	2. Outline specific instructions regarding insertion, standard/surgical ANTT, duration, replacement and on-going maintenance					
	3. Policies/procedures are reviewed on a regular basis					
2. Staff are trained on the insertion and on going management of invasive devices	1. Staff have received training e.g. online training/face to face/DVD on the UIPC principles relevant to the procedure					
	2. Training updates are provided in accordance with changes in regional/evidence based guidelines					
	3. Training includes competency based practice where appropriate and is updated as per local policy (e.g. questionnaire and observation) (ask staff/review doc)					
	4. Where infection rates and audit scores identify poor practice, further update training is undertaken as per local guidance (review documentation)					
3. High impact intervention tools/care bundles/quality improvement tool are in place	Review documentation: 1. High impact intervention tools/care bundles are available for example: - CVC (to include Umbilical venous and arterial catheters in neonates) - PVC - Urinary catheter - Renal Dialysis catheter - Chest drains (best practice) - Arterial Line (best practice)					
	2. Compliance is monitored					
	3. Results are feedback to relevant staff (review documentation)					

Section 2.2 – Invasive devices – There are systems and process in place to ensure a standardised and consistent approach in the insertion and ongoing maintenance of invasive devices						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	4. Compliance is independently verified if infection rates and audit scores identify poor practice, if self-scoring or validation compliance scores are low					
	5. Action plans are devised if required to improve practice					
4. ANTT precautions are used when accessing devices	1. Observe					
5. Hand hygiene is an integral part of the ANTT procedure	1. Hand hygiene is carried out in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
	2. Hand hygiene is audited in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
6. Hand washing is carried out in line with HSS (MD) (16/2012)	1. Staff use alcohol gel after hand washing when caring for the patient					
7. Skin preparation is carried out using the correct solution	1. 2% chlorhexidine gluconate in 70 %isopropyl alcohol and allow to dry for 30 seconds (refer to local policy for neonatal care/or local deviations) observe/ask staff					
	2. If infection rates and audit scores identify poor practice, the process for inserting invasive devices is reviewed (review scores/infection rates e.g. site infection)					
	3. Povidone – iodine on patients with sensitivity as per local policy					
8. Documentation is available for the insertion of invasive devices	Check care plan/patient notes/care bundle documentation for: 1. Date of insertion					
	2. Record of person who carried out procedure					
	3. Size of device used and batch number					
	4. Reason for insertion					

Section 2.2 – Invasive devices – There are systems and process in place to ensure a standardised and consistent approach in the insertion and ongoing maintenance of invasive devices						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
9. Catheter/cannula insertion site is regularly inspected and the appropriate dressings is in use	1. Dressings are sterile, adherent, transparent and semi permeable (observe)					
	2. Regular observation of site – at least daily for signs of infection(hourly IV/CVC check for neonates, renal catheter site at the beginning of each dialysis session) (check records)					
	3. Dressings are intact and dry at the time of inspection and changed regularly if transparent dressing not in use (observe/check documentation)					
	4. Urinary catheters – daily meatal hygiene is carried out (check records)					
10. Catheter/cannula access is carried out safely prior to accessing the line for administration of fluids or injections	1. 2% chlorhexidine gluconate in 70 %isopropyl alcohol (refer to local policy for neonatal care/ local deviations) is used for accessing ports or hubs (observe/ask staff)					
	2. If infection rates and audit scores identify poor practice, the process for accessing devices is reviewed (review scores/infection rates e.g. site infection)					
	3. Hubs or ports are allowed to dry for 30 seconds observe/ask staff					
11. Invasive devices are removed at the earlist opportunity in accordance with evidence based guidance	1. Staff are aware of the guidance for removal of invasive devices e.g. PVC (Review documentation)					
12. Infusions (IV) or drainage systems are maintained as closed systems	1. Infusions are maintained as closed systems (Observe)					
	2. Drainage systems are maintained as closed systems (Observe)					
13. Urinary catheter bags are secured and emptied	Observe: 1. Above floor level; not touching, resting or sitting on					

Section 2.2 – Invasive devices – There are systems and process in place to ensure a standardised and consistent approach in the insertion and ongoing maintenance of invasive devices						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
appropriately	floor					
	2. Below patient waist level					
	3. Clean disposable container for empting bags					
14. Administration (blood/fluid) set replacement is carried out in accordance with evidence based practice	1. Staff are aware of the guidance for replacement of administration sets (ref to local policy for neonates) e.g. 24hrs for blood and blood products and 72hrs for fluids					
	2. Administration sets are replaced as per guidance (Review documentation)					
15. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 2.3 – Taking Blood Cultures						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. A policy/procedure is available in accordance with evidence based practice	1. A policy/procedure is available					
	2. The policy/procedure is up to date					
2. Blood cultures are only taken when clinically indicated	1. The guidance includes clinical indications of when to take a blood culture (review documentation)					
	2. Staff are aware that blood cultures should be taken after identification of possible bacteraemia or sepsis and before administration of antibiotics where possible (Saving Lives, Best practice)(ask staff)					
3. The ANTT technique used prevents contamination and reduces the risk to patients	1. Staff who undertake the procedure are aware of the correct technique (ask/observe)					
	2. Technique (includes decontamination of blood culture bottle tops and skin, aseptic non touch technique (non touch of critical/key parts), blood culture bottle inoculated first if taking blood for other samples					
4. Hand hygiene is an integral part of taking blood cultures procedure	1. Hand hygiene is carried out in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
	2. Hand hygiene is audited in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
5. Blood cultures are documented in patient notes	1. Date, time, site					
	2. Clinical indicators for taking					
6. The procedure for taking blood cultures prevents contamination and reduces the risk to patients	1. Staff have received training e.g. online training/face to face/DVD					
	2. Training updates are provided in accordance with changes in regional guidelines/evidence based practice					
	3. Where infection rates and audit scores identify poor practice, further update competency based training is undertaken as per local guidance (review documentation)					

Section 2.3 – Taking Blood Cultures						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
7. The rate of positive blood cultures and incidence of contaminated and false positives is monitored, reviewed and acted upon	1. The lab regularly informs clinical/nursing/IPC staff of the rate of positive blood cultures within the unit (observe reports)					
	2. The rate of positive blood cultures are reviewed and discussed by clinical/nursing/IPC staff (check minutes of meeting)					
	3. The incidence of contamination is less than 3 per cent (Contamination is considered from a source other than the blood i.e. skin)					
	4. The incidence of false positive results are reviewed and discussed by clinical/nursing/IPC staff(check minutes of meeting)					
	5. Systems are in place to compare the rate of positive culture between clinical units within the trust (ask staff)					
	6. Action plans are devised if required to improve practice (review documentation)					
8. A quality improvement or best practice guidance tool is used when taking blood cultures	1. Compliance is monitored					
	2. Results are feedback to relevant staff (review documentation					
	3. Compliance is independently verified if infection rates and audit scores identify poor practice , self-scoring or validation scores are poor (review documentation)					
	4. Action plans are devised if required to improve practice					
9. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 2.4 - Antimicrobial prescribing						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Antimicrobial prescribing and management guidelines are available	1. Up to date guidelines have been developed (view guidelines)					
	2. Formulary and guidelines are reviewed by the microbiologist/infectious disease consultant, relevant consultant for speciality and pharmacist (check guidelines)					
	3. Guidelines are disseminated on induction and as part of training (ask staff, check training records)					
	4. Electronic/computer aided prescribing tools are available where appropriate					
	5. A trust wide multidisciplinary antimicrobial stewardship team is in place					
	6. There are clear links between antimicrobial stewardship and infection control					
2. Antimicrobial usage is monitored at ward/department level	1. Antimicrobial usage is audited is in line with antimicrobial prescribing guidance/local targets					
	2. Action plans are devised if required to improve practice					
	3. Results are communicated to relevant staff (ask clinical staff pharmacist, doctor, nurse)					
	4. Ward/department based pharmacist is in place					
	5. Antimicrobial ward rounds are carried out					
	6. Audit includes assessment of multidisciplinary information provided to patients on antimicrobial usage					
	7. A trust wide multidisciplinary antimicrobial stewardship team centrally reviews audit results and data analysis to identify risk factors in prescribing and antimicrobial resistance					
3. Antimicrobial prevalence (snap shot) audits are carried out as required	1. Check audits and ask staff					
	2. Check how deviations from the guidelines are actioned and escalated (check documentation)					

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Section 2.4 - Antimicrobial prescribing						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
4 Relevant documentation for prescribed antimicrobials is available	1. Documentation is available in the medical notes and kardex on the indication, drug prescribed, dose, frequency, route and planned duration or review date and previous antimicrobial history					
	2. The baseline investigations requested are documented					
	3. Microbiological samples are obtained (where possible) before administration of antibiotics					
	4. Microbiology results are reviewed and prescribing reviewed/de-escalate therapy as appropriate is undertaken (contact microbiologist if advice is required)					
5. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 2.5 – Clostridium *difficile* infection (CDI)						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. The protocol/care bundle includes guidance on critical points as per Regional Manual and CDI HII intervention	Check documentation, ask staff: 1. Isolation requirements					
	2. Prudent antimicrobial prescribing (reviewed daily)					
	3. Appropriate use of PPE					
	4. Environmental cleaning					
	5. Hand Hygiene					
	6. Patient/Care equipment cleaning					
	7. Bristol Stool chart in use					
	8. Specimen collection					
	9. Contact infection prevention and control for advice					
	10. Laundry advice					
	11. Waste guidance					
	12. Relatives/patient information					
2. Relevant documentation is completed	1. A CDI care pathway or equivalent documentation is in use					
	2. Completion of the care pathway or relevant documentation is audited by IPC					
	3. Results are fed back to relevant staff (review documentation)					
	4. Action plans are devised if required to improve practice					
3. Patients with CDI (suspected/confirmed) are immediately isolated	1. Isolation protocol is in place and known to staff					
	2. Patients suspected/confirmed with CDI are immediately isolated – check documentation					
	3. Infection control audits are carried out for achievement of isolation within agreed timescales i.e. time from CDI symptom onset to isolation (review audits carried out on isolation admission times)					
	4. Results are fed back to relevant staff (review documentation)					
	5. Action plans are devised if required to improve practice					

Section 2.5 – Clostridium *difficile* infection (CDI)						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
4. Hand hygiene is an integral part of management of CDI procedure	1. Hand hygiene is carried out in line with Regional Healthcare Hygiene and Cleanliness Audit Tool 2. Hand hygiene is audited in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
5. Hand washing is carried out in line with HSS (MD) (16/2012)	1. Staff use alcohol gel after hand washing when caring for the patient					
6. An antibiotic protocol is in place for patients who have or are suspected to have CDI	1. An antibiotic protocol is in place					
	2. Antibiotics are prescribed according to national/local policy; minimum use of broad spectrum antimicrobials/delay in prescribing (check for policy/audit)					
	3. Staff are aware of antimicrobial policy for CDI					
	4. Antimicrobial medication is reviewed daily (check notes)					
	5. Include stop dates in antimicrobial prescribing (check kardex)					
	6. Adherence to the policy is audited and results feedback to relevant staff					
	7. Action plans are devised if required to improve practice					
7. CDI high impact intervention tools/care bundles/quality improvement tool are in place and monitored	1. Compliance is monitored					
	2. Results are feedback to relevant staff (review documentation					
	3. Compliance is independently verified if infection rates and audit scores identify poor practice, if self-scoring or validation scores are poor (review documentation)					
	4. Action plans are devised if required to improve practice					

Section 2.5 – Clostridium *difficile* infection (CDI)						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
8. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 2.6 – Surgical site infection (SSI) (Some of this audit may only be measured by chart review)						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. A protocol/guidance/care bundle for preventing surgical site infection is available	1. Clinical staff display an awareness of the protocol/guidance/care bundle					
	2. The protocol includes critical steps to help prevent surgical site infection					
	3. Compliance is audited/monitored					
	4. Results reviewed and actioned by the multidisciplinary team (check documentation)					
	5. Compliance is independently verified if infection rates and audit scores identify poor practice , if self-scoring or validation scores are poor (review documentation)					
	6. Action plans are devised if required to improve practice					
2. Ward/Unit based preoperative care includes	1. Preoperative MRSA screening is carried out on specified patients (check policy)					
	2. Hair removal is not routinely undertaken (if required clippers are used, razors should not be used) (ask/check documentation)					
	3. Guidelines on showering prior to surgery (on day of or day before surgery using soap or surgical wash) (ask/check documentation)					
	4. Antibiotics are administrated at the appropriate time interval (ask/check records)					
3. Theatre based pre/perioperative care includes	Audit of this practice may only be available through reviewing the intra –operative notes: 1. Prophylactic antibiotic is prescribed in accordance with local policy (check records)					
	2. Antibiotics are administrated at the appropriate time interval (should be administered within 60 minutes prior to the operation, blade to skin). Only in lengthy operations (over 4 hours) may a second intraoperative dose be considered (ask/check records)					

Section 2.6 – Surgical site infection (SSI) (Some of this audit may only be measured by chart review)						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	3. 2 % chlorhexidine gluconate in 70 % isopropyl alcohol is used for skin preparation and allow to dry (refer to local policy for neonatal care/or local deviation) (ask staff)					
	4. If infection rates and audit scores identify poor practice, the process for skin cleansing is reviewed (review scores/infection rates e.g. site infection)					
	5. Povidone - iodine is used for patients with sensitivity (ask staff)					
	6. Body temperature is maintained above 36°C in the perioperative period (excludes cardiac patients) (check documentation)					
	7. Diabetic patients have their glucose level maintained <11mmol/l throughout the operation (check documentation)					
	8. The patients haemoglobin saturation is maintained above 95 per cent (if respiratory insufficiency this is maintained as high as is possible) (check documentation)					
	9. The wound is covered with a sterile wound dressing at the end of surgery (check documentation)					
4. Ward/Unit postoperative care includes	1. The wound dressing is kept in place for 48 hours (unless clinical indications indicate otherwise) (check documentation)					
	2. If there is excess leakage and need for a dressing change an aseptic non touch technique is used (ask staff)					
5. Hand hygiene is an integral part of preventing SSI	1. Hand hygiene is carried out in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
	2. Hand hygiene is audited in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
6. Hand washing is carried out in line with HSS (MD) (16/2012)	1. Staff use alcohol gel after hand washing when caring for the patient					

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Section 2.6 – Surgical site infection (SSI) (Some of this audit may only be measured by chart review)						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
7. SSI rates are part of the infection surveillance programme	1. SSI rates are reported to the PHA as part of regional surveillance (ask/check documentation)					
	2. The rate of SSIs are reviewed and discussed by clinical/nursing/IPC staff (check minutes of meeting)					
	3. Action plans are devised if required to improve practice (review documentation)					
8. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 2.7 – Ventilated (or tracheostomy) care						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. A protocol/guidance is in use to assist in the prevention of ventilator associated pneumonia (VAP)	1. Clinical staff display an awareness of the protocol/guidance					
	2. Competence based training has been provided					
2. The protocol/guidance includes the critical components	1. Sedation status to be reviewed and if appropriate stopped each day					
	2. Variations in observations which may indicate the presence of infection are routinely recorded e.g. temp/respiration/pain					
	3. All patients should be assessed for weaning and extubation each day (weaning protocol is in place were relevant) as per local policy					
	4. If clinically fit avoid supine position, aim for elevation of the bed head to 30°- 45°					
	5. Mouth care: Use chlorhexidine 2 % as part of daily mouth care (ref to local policy for neonates) (alternatives should be available for patients with allergies/skin sensitivity)					
	6. Endotracheal suctioning is carried out based on individual need using closed suctioning technique					
	7. There is appropriate humidification of inspired gas in accordance with local policy					
3. Compliance with the protocol/guidance is monitored	1. Compliance is audited/monitored					
	2. Results reviewed and actioned by the multidisciplinary team (check documentation)					
	3. Compliance is independently verified if infection rates and audit scores identify poor practice ,if self-scoring or validation scores are poor (review documentation)					
	4. Action plans are devised if required to improve practice					
4. Hand hygiene is an integral part of ventilated care	1. Hand hygiene is carried out in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					

Section 2.7 – Ventilated (or tracheostomy) care						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	2. Hand hygiene is audited in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
5. Hand washing is carried out in line with HSS (MD) (16/2012)	1. Staff use alcohol gel after hand washing when caring for the patient					
6. VAP rates are part of the infection surveillance programme	1. VAP rates are reported to the PHA as part of regional surveillance (ask/check documentation)					
	2. The rate of VAPs are reviewed and discussed by clinical/nursing/IPC staff (check minutes of meeting)					
	3. Action plans are devised if required to improve practice (review documentation)					
7. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 2.8 – Enteral Feeding or tube feeding is defined as a mode of feeding that delivers nutrients directly into the stomach, duodenum or jejunum (Gastrostomy (PEG), Jejunostomy, Naso/orogastric tubes)						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. A protocol/guidance is in use to assist in the prevention infection associated with enteral nutrition processes	1. Clinical staff display an awareness of the protocol/guidance					
	2. Competence based training has been provided					
2. Enteral feed is stored, used and disposed of as per trust policy	1. Pre packed ready to use enteral feeds are in use whenever possible					
	2. Stored as per manufacturer's instructions and where applicable food standard legislation (room temperature)					
	3. Used within expiry date					
	4. Tamper proof lids					
	5. A clean working area is provided and only equipment dedicated for enteral feed is used when decanting, reconstituting or diluting feeds					
	6. Additions to sterile containers are only made when there is no alternative and following an initial risk assessment					
	7. Unused enteral feed is disposed of as per local waste policy (not in hand washing sink)					
3. Insertion, set up and care of the enteral feeding system	1. Aseptic non touch technique used for insertion of device (Naso/orogastric tube)					
	2. The feeding tube is replaced as per local policy (ask staff)					
	3. Aseptic non touch technique used for connection and flushing					
	4. The line is labelled, dated and signed, (documented in patient records/line label)					
	5. Documentation includes as appropriate; who inserted tube, size, route of administration, PH and amount of aspirate, time and volume of feed, type of feed (check documentation)					
	6. The tube positioned is checked by PH indicator/x-					

Section 2.8 – Enteral Feeding or tube feeding is defined as a mode of feeding that delivers nutrients directly into the stomach, duodenum or jejunum (Gastrostomy (PEG), Jejunostomy, Naso/orogastric tubes)						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	ray/length of tube pre feed in neonates (X-rays not routinely used in neonates) (check records)					
	7. Daily Mouth care is provided					
4. Administration and maintenance of the enteral feeding system is carried out in accordance with evidence based practice	1. Administration sets and feed containers are single use					
	2. Administration sets are changed in line with local guidelines					
	3. Feeds are maintained as closed systems in line with manufacturer's guidance and local policy					
	4. Sterile water used in hospital patients, all patients fed via the jejunum or immune-comprised patients					
	5. Sterile water used for flushing systems is in date and discarded in line with manufactures instructions (not into hand washing sink)					
	6. Syringes used for flushing are single use					
5. Hand hygiene is an integral part of enteral feeding	1. Hand hygiene is carried out in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
	2. Hand hygiene is audited in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
6. Hand washing is carried out in line with HSS (MD) (16/2012)	1. Staff use alcohol gel after hand washing when caring for the patient					
7. Stoma site	1. ANTT dressing technique is used for first three days after initial placement or in line with local policy					
	2. In augmented care areas stoma site washed daily with sterile water and exposed as per local protocol					
	3. Dressings are used if there is a discharge or if patient choice					
8. Compliance with the protocol/guidance is monitored	1. Compliance is audited/monitored					
	2. Results reviewed and actioned by the multidisciplinary team (check documentation)					
	3. Compliance is independently verified if infection rates					

Section 2.8 – Enteral Feeding or tube feeding is defined as a mode of feeding that delivers nutrients directly into the stomach, duodenum or jejunum (Gastrostomy (PEG), Jejunostomy, Naso/orogastric tubes)						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	and audit scores identify poor practice , if self-scoring or validation scores are poor (review documentation)					
	4. Action plans are devised if required to improve practice (review documentation)					
9. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 2.9 – Screening and treatment for MRSA						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. An MRSA screening and treatment policy is in place	1. An up to date policy is in place					
	2. Staff display an awareness of and know how to access the policy					
	3. Adherence to the policy is audited with results shared and actioned by the multidisciplinary team (check documentation)					
	4. Compliance is independently verified if infection rates and audit scores identify poor practice , if self-scoring or validation scores are poor (review documentation)					
	5. Action plans are devised if required to improve practice (review documentation)					
2. The policy includes routine screening to be carried out in line with DHSSPS 'Best practice on Screening for MRSA colonisation' (HSS MD 12/2008) and local policy	1. Pre-operative certain surgical specialities e.g. elective orthopaedics, cardiothoracic, neurosurgery					
	2. Emergency orthopaedic and trauma admissions					
	3. Critical Care (including Intensive care and high dependency units)					
	4. Renal medicine					
3. The policy includes additional screening to be carried out based on a risk assessment in line with DHSSPS 'Best practice on Screening for MRSA colonisation' (HSS MD 12/2008) and local policy	1. All emergency admissions (ICU/Neonates all admissions)					
	2. All patients previously known to be MRSA positive					
	3. All elective surgical patients					
	4. Oncology/chemotherapy/haematology inpatients					
	5. Patients admitted from high risk settings e.g. nursing/care homes/transfers from another healthcare facility					
4. Decolonisation/suppression treatment is prescribed and carried out carried out in line with DHSSPS 'Best practice	1. Treatment is commenced immediately when patient is identified as an MRSA carrier (check records)					

Section 2.9 – Screening and treatment for MRSA						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
on Screening for MRSA colonisation' (HSS MD 12/2008) and local policy	2. Decolonisation treatment is not initiated when patient condition/risk assessed by IPC indicates otherwise e.g. skin condition					
	3. Treatment comprises of antibacterial shampoo, body wash and nasal cream or other sites as indicated in local policy (may differ in children/neonates) (check kardex)					
	4. Treatment is implemented three times daily for five days or as per local policy (may differ in children/neonates) (check kardex)					
	5. In augmented care areas decolonisation or suppression therapy as appropriate is commenced on admission to area and discontinued on receipt of screening results (not applicable if rapid screening method used, advice should be sought from the IPCT)					
5. Patients with MRSA (history/confirmed) are isolated as per local protocol	1. Isolation protocol is in place and known to staff					
	2. Patients with history/confirmed with MRSA are isolated in line with local guidance – check documentation					
	3. Infection control audits are carried out for achievement of isolation in line with local guidance (review audits carried out on isolation)					
	4. Results are fed back to relevant staff (review documentation)					
	5. Action plans are devised if required to improve practice					
6. The protocol/care bundle includes guidance on critical points as per Regional Manual	Check documentation, ask staff: 1. Isolation requirements					
	2. Prudent antimicrobial prescribing (reviewed daily)					
	3. Appropriate use of PPE					
	4. Environmental cleaning					
	5. Hand Hygiene					

Section 2.9 – Screening and treatment for MRSA						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	6. Patient/Care equipment cleaning					
	7. Specimen collection					
	8. Contact infection prevention and control for advice					
	9. Laundry advice					
	10.Waste guidance					
	11. Relatives/patient information					
7. Hand hygiene is an integral part MRSA management	1. Hand hygiene is carried out in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
	2. Hand hygiene is audited in line with Regional Healthcare Hygiene and Cleanliness Audit Tool					
8. Hand washing is carried out in line with HSS (MD) (16/2012)	1. Staff use alcohol gel after hand washing when caring for the patient					
9. Relevant documentation is completed	1. An MRSA care pathway or equivalent documentation is in use					
	2. Completion of the care pathway or relevant documentation is audited by IPC					
	3. Results are fed back to relevant staff (review documentation)					
	4. Action plans are devised if required to improve practice					
10. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Documentation for Infection Prevention and Control Clinical Practices Audit Tool

The following policies/procedures/audits and related documentation is associated with the Clinical Practices Audit Tool and are required:

Policy/Procedures/Guidelines

- Aseptic non touch technique (ANTT) policy
- Policy/procedure for insertion and on-going management of devices – central venous catheter, peripheral vascular catheter, urinary catheter
- Policy/procedure for taking blood cultures
- Antimicrobial prescribing and management guidelines
- Protocol for management of Clostridium *difficile*
- Protocol/guidance for preventing surgical site infection
- Protocol/guidance to assist the prevention of ventilator associated pneumonia
- Protocol/guidance to assist in the prevention of infection associated with enteral feeding
- MRSA screening/treatment policy in place

Audits

- Audit of care bundles/high impact interventions, compliance, relevant action plans, independent verification
- Audit of compliance with best practice for taking blood cultures, compliance, relevant action plans, independent verification
- Audit of antimicrobial usage, compliance, relevant action plans
- Audit of completion of Clostridium *difficile* care pathway, compliance, relevant action plans
- Audit of adherence to isolation and antimicrobial guidelines for management of Clostridium *difficile,* compliance, relevant action plans, independently verification
- Audit of adherence to MRSA screening/treatment, compliance, relevant action plans, independent verification

Associated Documentation

- Reports on blood culture results and false positive rates
- Action plans to address blood culture results/false positives as appropriate
- Carepathway for Clostridium *difficile*
- Reports on rates of ventilator associated pneumonia

- Surgical site infection rates

Meetings

- Meetings to demonstrate feedback of relevant information e.g. audit scores, action plans, compliance rates
- Meeting to discuss results of blood cultures
- Meeting to discuss results of ventilator associated pneumonia
- Any other relevant minutes of meetings

Training

- Records of ANTT training
- Records of competency based training for invasive devices were applicable e.g. cannulation
- Evidence of training for staff taking blood cultures
- Evidence of antimicrobial training for prescribers